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No. 95-1533

PROGRAM EVALUATION

MEDICARE AMENDMENTS OF 1978

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

to accompany

H.R. 13097

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95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 95-1533

MEDICARE AMENDMENTS OF 1978

AUGUST 31, 1978.—Ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 13097]

The Committee on Ways and Means, to whom was referred the bill (H.R. 13097) to amend certain provisions of title XVIII of the Social Security Act as they relate to the medicare program established by part A of such title, having considered the same, reports favorably thereon with amendments and recommends that the bill do pass.

The amendment to the text of the bill is a complete substitute therefor and appears in italic type in the reported bill.

The title of the bill is amended to reflect the amendment to the text of the bill.

I. PURPOSE AND BACKGROUND OF THE BILL

As a result of hearings and investigations conducted during the last several years, your committee has come to the conclusion that a number of benefit and administrative improvements in the medicare program are necessary and appropriate at this time. Your committee recognizes that, in addition to the provisions contained in this legislation, a number of other liberalizations in the medicare benefit structure also would be desirable. However, in recognition of the budgetary limitations which prohibit extensive benefit expansions at this time and because of the general concern about the present rapid rate of increase in health care costs, your committee has provided for only limited improvements in medicare benefits, often making difficult choices between equally meritorious and deserving alternatives in order to keep this legislation within the increase in medicare outlays that has been included in the congressional budget resolutions for Fiscal Year 1979 in anticipation of the enactment of this bill.

On June 19 and 22 of this year, your committee's Subcommittee on Health conducted two days of public hearings on possible amendments to the medicare program. During its deliberations on these issues in executive session on August 8, the Subcommittee on Health developed a number of medicare proposals which it included in H.R. 13097, that relate to benefits, enrollment requirements and general program administration and which stay within the scope of the budgetary limitations the committee established in its budget request. These recommendations were submitted to the full Committee on Ways and Means on

August 14. On August 16, the full committee considered H.R. 13097, as amended, and ordered it reported, with further amendments.

Your committee fully recommends this legislation, noting that it provides for important benefit expansions as well as for more efficient administrative procedures, yet recognizes the need for exercising discipline in enacting medicare improvements in light of budgetary limitations. The committee wishes to stress that there were a significant number of other medicare improvements which could also have been favorably considered at this time. However, because of budget constraints, your committee was forced to make difficult decisions about what benefit improvements should be made in the program at this time and what potential benefit improvements might best be reviewed at a later date. Your committee believes its bill represents an equitable approach to limited program expansion at this time from the perspective of both beneficiaries and taxpayers, but your committee remains committed to continuing its efforts to improve the medicare program as conditions permit.

II. SUMMARY OF THE BILL

As approved by the Committee on Ways and Means, H.R. 13097 would provide for a number of improvements in medicare benefits including liberalization of the home health benefit; elimination of the second waiting period for reentitled disability beneficiaries; coverage for services furnished in community mental health centers and outpatient rehabilitation facilities; and authority for the President to enter into reciprocal agreements with other countries to provide hospital and medical services to medicare beneficiaries while outside the United States. Among other changes are benefit improvements relating to services furnished by dentists, optometrists, and chiropractors.

Your committee's bill would also provide for several improvements in the administration of the medicare program. The Secretary of Health, Education, and Welfare would be provided authority to exercise flexibility in the application of medicare standards to rural hospitals. Your committee's bill would also direct the Secretary to establish additional standards and requirements for home health agencies. In addition, a number of minor provisions in the medicare law relating to administration and enrollment have been modified or, where found to be no longer necessary, eliminated.

III. GENERAL STATEMENT

Short Title (Section 1)

This Act may be cited as the "Medicare Amendments of 1978."

Home Health Services (Section 2)

Since the beginning of the medicare program, home health benefits have been available under both part A—hospital insurance—and part B—medical insurance.

To be eligible for home health care, the beneficiary must be: (1) essentially confined to his home, (2) under the care of a physician, and (3) in need of skilled nursing care, speech therapy, or physical therapy. If all these requirements are met, an individual is eligible for the full range of home health services.

The home health benefit under part A of medicare was designed to encourage early discharge of hospital and skilled nursing facility (SNF) patients who continue to need skilled care but not at the intensive level provided for in a hospital or SNF. The part B benefit—no prior hospitalization required—offers those who require skilled care an alternative to or postponement of hospitalization. In order to maximize these objectives, your committee believes it would be appropriate to make certain liberalization in the home health benefit.

The bill would liberalize the medicare home health benefit in the following manner: (1) unlimited visits would be available under both parts A and B; (2) the present three-day prior hospitalization requirement under part A would be eliminated; (3) home health benefits under part B would no longer be subject to the $60 deductible; and (4) the present requirement that proprietary home health agencies be licensed under state law in order to participate in medicare would be eliminated.

In addition, the Secretary of HEW would be provided authority to establish additional standards and reimbursement guidelines for the effective administration of the home health benefit; home health aides would be required to complete an appropriate training program, the physician who performs the certification for home health services and establishes the plan of treatment would not be permitted to have a substantial financial or ownership relationship with the home health agency; and the Secretary would be directed to designate regional intermediaries for home health agencies.

Increase in the number of visits under parts A and B.—Beneficiaries are presently eligible for 100 visits per benefit period during the year following a hospital stay of at least three days under part A and 100 visits per calendar year under part B. This provision would eliminate the limitation on visits under each part.

Elimination of the three-day prior hospitalization requirement under part A.—In order to receive home health benefits under part A,

beneficiaries must be hospitalized for at least three consecutive days. Elimination of this requirement would be particularly helpful to the more than 1.1 million beneficiaries who have only part A of medicare; presently they do not have access to the home health benefit unless they have met this prior hospitalization requirement.

Elimination of the part B $60 deductible with respect to home health services.—In 1972, legislation was enacted which exempted the part B home health benefit from the 20-percent coinsurance applicable to other part B services. Elimination of the part B $60 deductible with respect to such services would eliminate the remaining patient cost-sharing on home health services.

Elimination of the licensing requirement for proprietary home health agencies.—By law, proprietary, or for-profit, home health agencies are not eligible to participate in the medicare program unless the agency is licensed pursuant to state law and meets such additional standards and requirements as may be prescribed in regulations. Currently, 16 states license proprietary home health agencies. With respect to additional standards which by law may be imposed on proprietary home health agencies, it is required that such agencies offer skilled nursing services and one other therapeutic service directly, whereas public and nonprofit agencies are allowed to contract for either the skilled nursing service or the other therapeutic service. This provision would eliminate the additional licensing requirement under medicare pertaining to proprietary home health agencies and the authority of the Secretary to establish additional standards solely on the basis of the tax status of the agency.

In addition to the liberalizations in the home health benefit, your committee's bill also includes several provisions to assure the more efficient and economical administration of the benefit. These administrative reforms are the direct result of the coordinated work of the Subcommittees on Health and Oversight during the past three years. The Subcommittees' investigations have made obvious the need for more uniform reimbursement policies, a tightening of conditions of participation for home health agencies, and general improvement in administration of the home health benefit by medicare intermediaries.

Regional intermediaries for home health agencies.—The committee bill requires the Secretary to establish regional intermediaries for home health agencies. The committee has found a wide variation in administrative and reimbursement practices among intermediaries with respect to home health providers. This is in part attributable to the small proportion of an intermediary's medicare business that is devoted to this particular type of provider as well as the rapid increase in recent years of the number of home health providers. The purpose of requiring the Secretary to designate regional intermediaries is to allow specific intermediaries to develop expertise in this area and allow them to make meaningful cost and performance comparisons of home health agencies in the same general geographic area.

In administering this requirement, the Secretary should establish regions and select intermediaries for those regions in a manner that will best promote the purposes and goals of this provision. It is the intention of the committee that home health agencies shall still retain the present law option of electing to be reimbursed directly by the med-

icare program rather than through an intermediary. This provision makes no change in the selection or operation of the intermediary process under existing law for providers of services other than home health agencies.

Home health aides.—The committee bill modifies the present provision of the home health benefit which covers services furnished by a home health aide on a part-time or intermittent basis by requiring that such aides meet certain qualification standards. It has come to the attention of the committee that, in some cases, aides have been used to provide services under the medicare home health benefit who have no prior training or experience in caring for the medical needs of the aged and disabled. This has been found to be particularly true in the case of some agencies which do not directly employ home health aides, but contract out for those services, sometimes with personnel agencies which supply general temporary help. The committee bill makes it clear that home health aides, whether employed directly by the home health agency or made available through contract with another entity, must have completed a training program approved by the Secretary.

Physician certification.—The committee bill requires that the physician who performs the required certification with respect to home health services and establishes and reviews the plan of treatment cannot be a physician who has a significant ownership interest in or a significant financial or contractual relationship with the home health agency that is providing the service to the medicare beneficiary.

The committee has found that some home health agency patients have had their certifications or plans of treatment signed and authorized by physicians who are medical directors or owners of the provider home health agencies. The committee bill would prevent potential conflicts of interest from arising as part of the certification and plan of treatment process.

Other administrative requirements.—The committee bill authorizes the Secretary to establish such other administrative requirements for home health agencies as he finds necessary for the effective and efficient operation of the program. It is the committee's intent to provide sufficient direction to the Secretary to insure the development of more adequate administrative and reimbursement guidelines and, at the same time, provide the Secretary with authority to establish such additional guidelines or requirements he deems necessary. For example, the Health and Oversight Subcommittees' investigations of this area have suggested that it may be necessary for those home health agencies which serve primarily medicare beneficiaries to meet additional requirements to limit potential losses of the program. In particular, your committee expects the Secretary to take the following actions prior to the July 1, 1979, implementation of the home health benefit improvements provided in the bill:

Promulgate caps under the authority of section 223 of P.L. 92–603 covering overall home health costs and where appropriate other specific categories of home health costs;

Develop and promulgate detailed guidelines for home health utilization;

Clarify the rules that deny medicare funding for patient solicitation activities by home health agencies;

Develop and implement for agency fiscal years beginning after June 30, 1979 a new, more detailed home health agency cost reporting system;

Develop a requirement that home health agencies hold themselves out to serve both medicare and nonmedicare patients in order to obtain medicare certification; and

Develop criteria to limit participation of or reimbursement in agencies that do not engage in excessively expensive or unreasonably long-term contracts for management or administrative services.

It is the committee's expectation that these administrative improvements, as well as others the Secretary might find appropriate to implement either by June 30, 1979 or later can and should improve the administration of the home health benefit so as to protect the fiscal integrity of the program.

Elimination of the Second Waiting Period for Reentitled Disability Beneficiaries (Section 3)

Under the bill, entitlement to medicare benefits would be provided for individuals who have been entitled to disability payments for a total of 24 months, regardless of whether those 24 months were consecutive. In that way, an individual who has satisfied the 24-month requirement and attempts unsuccessfully to return to work would be immediately entitled to medicare benefits when he resumes receiving monthly disability benefits.

Medicare protection is provided for individuals after they have been receiving social security cash benefits on the basis of disability for 24 consecutive months. Should a beneficiary recover sufficiently to engage in gainful employment, his disability cash benefits and his medicare coverage are terminated. If the individual becomes disabled a second time within 5 years, he immediately regains entitlement to cash disability benefits, but he must once again satisfy the 24-month waiting period requirement to qualify for medicare protection.

The purpose of the immediate reentitlement to cash disability benefits is to encourage disabled persons to attempt a return to work if their conditions improve, without fear of forfeiting entitlement to cash benefits for an extended period should the attempt be unsuccessful. The 24-month waiting period for reentitlement to medicare benefits appears to be inconsistent with this intent and can serve as a disincentive to work attempts. Moreover, there is concern that the waiting period provision works an undue hardship on those individuals who try, but are unsuccessful, in their attempts to return to gainful employment. Accordingly, your committee's bill eliminates the requirement that the months be consecutive in the 24-month medicare waiting period for disability beneficiaries.

Reciprocal Agreements for Coverage Outside the United States (Section 4)

The bill authorizes the President to enter into reciprocal agreements with other countries to provide hospital and medical benefits for medicare beneficiaries living or traveling outside the United States.

Under present law, medicare coverage is provided, with a few limited exceptions, only for health care services rendered within the United States. These exceptions cover only cases in which the beneficiary needs emergency hospital services while traveling in Canada between the 48 contiguous states and Alaska; or needs hospital services because of a medical problem that arose while traveling or residing within the United States near the border, and a Canadian or Mexican hospital is more accessible than the nearest United States hospital. This limitation on medicare coverage was included in the law because of the administrative problems involved in verifying the medical necessity for services furnished outside the United States, establishing the qualifications of foreign medical practitioners and institutions, and determining the appropriate amount of payment to make for services.

A significant number of medicare beneficiaries are deprived of their medicare benefits during such times as they may be traveling or living outside the United States. Since the basis of the limitation in present law is administrative, your committee believes that considerations of equity dictate the development of a reasonably workable arrangement for assuring medicare protection, to the extent feasible, for such beneficiaries.

Your committee recognizes that there are limitations in the approach included in the bill to providing coverage outside the United States. The negotiation process is likely to be time-consuming (although the bill provides authority, pending the conclusion of an agreement, for the Secretary to enter into interim arrangements with accredited hospitals in a country if serious negotiations are in progress), and there is the possibility that some countries will choose not to enter into an agreement. Moreover, the bill includes certain restrictions on the authority to negotiate such agreements. For example, no reciprocal agreement negotiated under the authority granted by the bill may provide entitlement to benefits in the United States for foreign nationals who do not meet medicare's entitlement requirements with respect to age or medical condition (regardless of that individual's status under his country's program), or authorize any individual to receive benefits in the United States on a reciprocal basis in excess of those benefits provided for medicare beneficiaries. Nevertheless, your committee believes that the use of reciprocal agreements represents the most effective method at this time to begin to overcome the administrative and technical obstacles that have heretofore precluded any coverage for services furnished to beneficiaries while they are outside the United States.

Dentists' Services (Section 5)

The bill would modify present law to cover services performed by dentists where those services are presently covered when performed by physicians. The bill would also cover hospital stays for the performance of noncovered dental services where the severity of the dental procedure warrants hospitalization.

Under present law, services furnished by dentists are covered under part B of medicare, but only with respect to: (1) Surgery of the jaw or any structure contiguous to the jaw, or (2) reduction of any fracture of the jaw or facial bone. Payment for routine dental services is

specifically excluded. Medicare also provides for coverage of hospitalization where—because of his underlying medical condition—a beneficiary requires hospitalization in connection with the provision of noncovered dental services. However, there are some services which are regularly performed by both physicians and dentists, but which are covered under medicare only if performed by a physician. For example, certain procedures and services relating to treatment of oral infections are covered when furnished by a physician but are not covered when furnished by a dentist. Such functions do not involve routine dental care, which is separately excluded under existing law whether performed by a dentist or a physician. It is your committee's belief that it would be appropriate to provide the same coverage for services performed by a dentist (which are within the scope of his state license) that is provided for services performed by physicians. The present exclusion of routine dental services would remain in effect.

Your committee also concluded that present coverage for inpatient hospital services related to certain noncovered dental procedures is inadequate. The test for medicare coverage of the inpatient services is the patient's underlying condition (e.g., history of heart failure). The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization. Accordingly, your committee's bill would provide for coverage of hospital stays where hospitalization is warranted by the severity of the patient's dental condition.

Treatment for Plantar Warts (Section 6)

Your committee's bill would eliminate the present exclusion of services related to treatment of plantar warts.

Under present law, coverage for services related to routine foot care—which is defined as "including the cutting and removal of corns, warts, or calluses, trimming of nails, and other routine hygienic care"—is specifically excluded.

Warts on the feet (often called plantar warts because they may appear on the plantar surface of the foot), are tumors caused by infectious viral agents. However, because of the routine foot care exclusion in present law, treatment for plantar warts is not a covered service, while the treatment of warts located elsewhere on the body is a covered service. Your committee is concerned about this inconsistency in present law and the committee bill therefore eliminates the present exclusion on coverage of services related to the treatment of plantar warts.

Community Mental Health Centers (Section 7)

The bill provides that services furnished in qualified community mental health centers would be reimbursed under part A of medicare on the basis of the cost incurred in providing the covered services. Up to ten outpatient visits per year would be covered and up to 60 partial hospitalization visits per year would be covered. (Reimbursement for a center's services would reflect the cost of each type of visit.) Beneficiaries would exchange one day of their 190-day lifetime

limit on inpatient psychiatric hospitalization for every four partial hospitalization visits to a qualified community mental health center. Since they would be covered under part A of medicare, mental health services provided by a qualified community mental health center would not be subject to the part B deductible coinsurance, or $250 yearly limit applicable to outpatient mental health services furnished by psychiatrists or other physicians.

Community mental health centers are not specifically recognized under present law. Services furnished by a community mental health center which is physician-directed are presently covered either as physicians' services or services furnished "incident to" a physician's service (e.g., services of psychologists and other professionals). Services furnished in community mental health centers which are not physician-directed are not generally covered under the medicare program.

Since 1963, the Federal Government has been involved in efforts to develop community mental health centers which offer a range of outpatient mental health services in the expectation that such centers would replace large inpatient institutions as the primary place of treatment for the mentally ill. Your committee believes that the current medicare limitations on the coverage of outpatient mental health services are not consistent with this larger objective.

Your committee recognizes that there are differences within the health care community as to the strict applicability of the medical model to the diagnosis and treatment of mental disorders. Thus, while standard medicare terminology is used for definitional purposes in the bill, your committee intends that this terminology be understood and applied within the framework of accepted prevailing practices followed by qualified community mental health centers in the provision of mental health services. Hence, the use of the term "medically necessary" with respect to a physician's certification is not meant to be restrictive but rather to be interpreted with sufficient breadth as to include such psychologically disabling conditions as phobias, neuroses, and severe depressions. Similarly, it is the intent that periodic review and approval of a plan of treatment be conducted by a center's duly constituted treatment review committee, of which the physician is a member, composed of members of the several disciplines involved in the care and treatment of the patient. In addition, while the physician certification with respect to partial hospitalization visits must include a judgment as to the patient's need for institutionalization in the absence of partial hospitalization visits, it is not the intent that such a judgment need imply that institutionalization would otherwise be required immediately.

The use of the term "diagnostic and therapeutic services" in the definition of covered community mental health services is intended to also encompass those liaison and coordination services furnished by qualified mental health personnel of the center as part of the overall management of patient care. Also, the use of the term "physician supervision" in the community mental health center setting is not intended to imply daily, "over-the-shoulder" supervision of all the services furnished in the center; rather the intent is that there be general supervision of overall management of the patient's care and that the physician be available for advice and consultation as needed.

Your committee's bill would extend recognition as qualified providers under part A only to those centers meeting the definition of and requirements for a community mental health center contained in the Community Mental Health Center Act and the regulations prescribed thereunder. However, your committee expects the Secretary to develop comparable standards, in consultation with appropriate professional organizations, (including the Joint Commission on Accreditation of Hospitals), for the possible future coverage of other outpatient mental health centers, and to submit to the Congress such recommendations as he finds appropriate with respect to coverage and standards for such centers.

Comprehensive Outpatient Rehabilitation Centers (Section 8)

Comprehensive outpatient rehabilitation centers would be recognized under your committee's bill as providers of services under medicare. Such rehabilitation centers could be public or private institutions primarily engaged in providing under medical direction diagnostic, therapeutic, and restorative services to outpatients and would be required to meet specified conditions of participation.

Under present law, medicare covers certain rehabilitation services in a variety of settings under various coverage provisions. Such services are included among the services that may be reimbursed on a charge basis as "incident to" the services of a physician. Outpatient physical therapy and outpatient speech pathology services are covered on a cost-related basis when furnished by a clinic, rehabilitation agency or public health agency; however, this coverage provision does not include occupational therapy and other rehabilitation services. Services furnished by an independently practicing physicial therapist in the office setting are also covered, but there is an $80 annual limit on the amount medicare will pay for such services.

Present law does not provide coverage for a broad array of rehabilitation services where these are furnished on an outpatient basis in a coordinated fashion by a comprehensive outpatient rehabilitation facility. Your committee's bill would make provision for such coverage, including the coverage of occupational therapy, by recognizing such facilities as providers of services if they meet specified conditions of participation and by providing reimbursement under part B for the services ordinarily furnished by such facilities based on the costs they incur in furnishing covered services to medicare beneficiaries.

Optometrists' Services (Section 9)

Your committee's bill would provide coverage for services furnished by optometrists in connection with treatment of aphakic patients (patients without the natural lens of the eye). Also, the Secretary would be directed to report to the Congress as to specific legislative recommendations for implementing coverage for services furnished by optometrists for treatment of cataracts.

Present law specifically excludes payment for eyeglasses, eye examinations for the purposes of prescribing, fitting, or changing eyeglasses, and procedures performed to determine the refractive state of the eye. However, post-surgical lenses for aphakic patients are covered as prosthetic devices when prescribed by a physician or an optometrist.

While medicare will cover the cost of a physician's examination to determine the need for the prosthetic lenses, the cost of the same service when furnished by an optometrist is not covered. The only services for which optometrists may be reimbursed under present law are dispensing services in connection with the actual fitting and provision of such prosthetic lenses.

A study was conducted by the Department of HEW in 1976 to determine the appropriateness of medicare coverage for services furnished by optometrists. The expert consultants to the study concluded that medicare coverage should be extended to those services that an optometrist is legally authorized to perform in connection with the treatment of aphakia and cataracts. However, HEW recommended that, while optometrists' services related to aphakia should be covered at the present time, it would be inappropriate to provide coverage for services furnished by optometrists to cataract patients until the Department has had an opportunity to resolve a number of administrative issues related to such matters as delivery pattern changes, utilization controls, an operational definition of cataracts, and cost controls. In light of these considerations, your committee's bill provides for the coverage of optometrists' services to aphakic patients and directs the Secretary to complete his analysis of the pending administrative issues and submit legislative recommendations with respect to medicare reimbursement for optometrists' services for cataract patients.

Demonstration Projects for Hospice Services (Section 10)

Your committee's bill directs the Secretary to conduct demonstration projects to acquire necessary information and data with respect to reimbursement for hospice services under medicare.

The objective of a hospice is to assist a terminal patient and his family to adjust to his condition and to provide in the home and in other supportive settings such medical and social services as the patient and family might need. In the case of a medicare beneficiary, some of these services would be payable under part B—for example, physicians' services, durable medical equipment, and, if the patient is homebound and otherwise qualifies, home health benefits—but in most cases, medicare coverage would be limited and payment would be fragmented. Payment would be made to the individual practitioners and suppliers rather than to the hospice itself. Under present law, the hospice itself is not recognized as a "provider of services."

Your committee believes that a hospice can help many terminally ill patients to remain at home (with only occasional visits to or stays in an institution) thereby avoiding continuous institutionalization in a hospital or nursing home. However, it is generally recognized that insufficient information and experience are presently available to design a feasible medicare coverage provision. Many hospice services—for example, counseling by social workers and ministers, homemakers, self-administerable drugs for use in the home—are not now covered by medicare. Moreover, uniform criteria and standards for the organization, management, and quality of hospices have not as yet been developed. Nor is it clear whether and in what ways such an organization and its services might be related to or integrated with the services rendered by other agencies in the same community. As a result, your committee believes it would be most appropriate at this time to

authorize medicare demonstration projects to acquire the necessary information and data with respect to alternative ways for covering and providing reimbursement for hospice services.

Study of Coverage for Orthopedic Shoes (Section 11)

Your committee's bill directs the Secretary to study and submit legislative recommendations to the Congress with respect to the coverage of orthopedic shoes where such shoes are required as an appropriate part of medical treatment.

Under present law, orthopedic shoes and other supportive devices for the feet are generally excluded from medicare coverage. The only situation in which exclusion does not apply is if the orthopedic shoe is provided as an integral part of a leg brace.

Orthopedic shoes are often prescribed by physicians in connection with the treatment of deformities or diseases of the legs or feet. In some cases, ambulation is extremely difficult without the appropriate orthopedic shoes; in many cases, such shoes can represent a significant expense for the individual beneficiary.

Your committee recognizes the potential benefit that might be derived from coverage of orthopedic shoes in appropriate cases, particularly with respect to individuals whose use of such prescribed shoes may help to forestall the eventual need for amputation. However, there appears to be insufficient information about the scope of the potential medical need for orthopedic shoes, the criteria for assessing the appropriateness of coverage in specific cases, the qualifications of personnel dispensing such equipment, and the cost implications of such coverage to permit the development of a reasonable coverage provision. Consequently, the committee believes that the most desirable action at this time is to direct the Secretary to promptly conduct such studies as are necessary to acquire the needed information and to submit to the Congress, by January 1, 1980, legislative recommendations for extending coverage in appropriate cases to the use of orthopedic shoes.

As is true in the case of orthopedic shoes, your committee also recognizes that benefits may be derived from the coverage of other health services such as those related to the fitting, prescribing, and patient use of hearing aids or certain low-vision aids. However, the committee is concerned that there is insufficient information and data on the cost and utilization of such services (although it is generally recognized that any coverage in areas such as these would be expensive). The committee believes, therefore, that there is a need for HEW to explore these issues so that your committee might subsequently consider alternatives for providing more coverage in these areas and make the most informed judgments possible in regard to these and other complex coverage issues.

Antigens (Section 12)

The bill would allow payment to an allergist for the preparation of a reasonable supply of an antigen, including a supply forwarded to another physician or a rural health clinic for administration.

Under present law, medicare coverage of drugs and biologicals (including antigens) is limited to those drugs and biologicals which (a) cannot be self-administered, (b) are commonly furnished in

physicians' offices incident to a physician's professional service, and (c) are commonly either rendered without charge or included in the physician's bill. Thus, the cost of antigens can be covered, but only where their preparation and administration is an integral part of the allergist's service and represents an expense to him. Your committee's bill would allow payment to an allergist for the preparation of a reasonable supply of antigen, including a supply forwarded to another physician or a rural health clinic for administration.

In the case of a beneficiary who lives some distance from his allergist, the allergist diagnoses the patient's allergy and prepares an antigen with which to treat it; and often, the patient's family physician performs the actual administration of the antigen. Under present law, however, the cost of the antigen is not covered unless the allergist who prepared the antigen also administers it. This creates a financial hardship for a beneficiary who lives too far from his allergist to travel back and forth for the regular administration of the antigen, since he must pay for the antigen himself. Your committee's bill would remedy this by allowing payment for the antigen even where the allergist does not administer it.

Payment Where Beneficiary Is Not at Fault (Section 13)

Your committee's bill authorizes the Secretary to make payment where a medicare beneficiary who medically required a higher level of care was erroneously placed in a distinct part of an institution designated to offer a lower level of care.

Under present law, a hospital may designate a "distinct part" of its facility (i.e., an entire, physically identifiable unit consisting of all the beds in that unit, such as a separate building, floor, ward or wing) and have it qualify for participation in medicare as a skilled nursing facility. Patients located in the "distinct part" skilled nursing facility are entitled to skilled nursing facility benefits, but not hospital benefits. (The purpose for permitting such distinct parts is to assure ease of transfer while maintaining continuity of medical supervision for patients who no longer require hospital services but do require skilled nursing facility care.)

A skilled nursing facility may similarly designate a "distinct part" which participates in medicare as a skilled nursing facility, while the remaining part of the institution serves as a nonparticipating domiciliary or intermediate care facility. Only patients located in the participating skilled nursing facility distinct part are entitled to medicare skilled nursing facility benefits.

There have been instances in which a patient who requires inpatient hospital services has been inadvertently or erroneously placed in a bed in the skilled nursing facility distinct part of the hospital as a result of a professional or administrative error in judgment. In such cases, the beneficiary's claim for medicare hospital benefits has been denied. Similarly, there have been instances in which nursing home patients have been placed, on the basis of erroneous professional or administrative judgments, in beds in the nonparticipating part of the facility, thus depriving them of their entitlement to skilled nursing facility benefits. In neither case of this type is the beneficiary in a position to make a choice or influence the action taken by the facility or hospital.

Your committee is concerned that under present law beneficiaries must bear the adverse consequences resulting from erroneous professional judgments as to the appropriate level of care required and erroneous or inadevertent provider administrative actions in the placement of a patient. Accordingly, the committee's bill authorizes the Secretary to make payment in such situations—on a case-by-case basis—where he determines that the beneficiary medically required the higher level of care that should have been provided. Thus, payment could be made under this provision where the erroneous transfer was caused by: (1) An action of a utilization review committee, a professional standards review organization, a fiscal intermediary, or (2) a provider of services which, acting in good faith, inadvertently or erroneously assigned the patient to the wrong bed.

It is the committee's intent that this authority to provide payment for certain noncovered services be used in appropriate cases only; that is, where it is clear that an error has been made. It is expected that the Secretary will take all necessary steps to assure that this provision is not abused.

Flexibility in Application of Standards for Rural Hospitals (Section 14)

The bill authorizes the Secretary to apply medicare standards to rural hospitals more flexibly to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which if rigidly applied would result in unreasonable financial hardship for a rural hospital; but only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

Under present law, to participate in medicare, a hospital must satisfy certain statutory conditions of participation relating to health and safety standards, physical plant, organizational arrangements, and qualified medical, nursing, and technical staff. The Secretary is authorized to prescribe additional requirements he finds necessary in the interest of the health and safety of patients. (Many requirements relating to fire and safety precautions have been promulgated in accordance with this regulatory authority.) Current law also provides authority for the Secretary to waive the statutory 24-hour registered professional nursing service requirement in the case of a rural hospital where he determines the hospital is needed to serve the individuals in the area and the hospital is making a good faith effort to comply with the 24-hour requirement but such compliance is impeded by a lack of qualified nursing personnel in the area. This waiver authority expires on December 31, 1978.

Many professional people contend that medicare's health and safety standards are designed primarily for large urban hospitals and that, consequently, the rigid application of these standards to rural hospitals, many of which provide a lesser range of services and have limited access to the services of technical personnel, creates unnecessary financial and management burdens. While your committee does not share the view that different or lesser standards ought to be applied to rural hospitals—since the intent of requiring compliance with basic standards is to uniformly assure the safety and quality of care for all

patients—your committee does believe it is necessary to provide for some flexibility in the application of national standards. Such flexibility, however, would be permissible only to the extent that it does not jeopardize or adversely affect the health and safety of patients.

Under this provision of your committee's bill, it would still be necessary for the Secretary to assure that there is compliance with appropriate quality and safety requirements. For example, with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may provide for a temporary waiver of the requirements only for such period as he determines that the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area, a registered nurse is present on the premises to render or supervise the nursing service during at least the regular daytime shift, and the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients. Similar tests are to be applied by the Secretary with respect to other types of technical personnel, including tests related to the scope of services furnished by the facility and the facility's good faith efforts to fully comply with personnel requirements. The underlying premise, however, is that the Secretary will exercise the authority herein granted to apply standards with some flexibility only when he is satisfied that the health and safety of patients will not be jeopardized and that those services rendered by the affected facilities are delivered in a manner that is consistent with reasonable standards for such facilities.

Certification and Utilization Review by Podiatrists (Section 15)

Under the bill, podiatrists, acting within the scope of their practice, would be recognized by medicare for purposes of physician certification and participation as physicians in utilization review. This recognition would be extended where consistent with State law and the policies of the health care institutions involved.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requires that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. For neither purpose does a podiatrist qualify as a "physician."

Since medicare covers as "physicians' services" the services performed by podiatrists within the scope of their practice, your committee concluded that medicare should also recognize podiatrists as physicians for purposes of physician certification and participation in utilization review.

The bill extends this recognition to certification and utilization review activities that are consistent with the functions the podiatrist is legally authorized to perform in the state where he practices, and where this recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrist acting as a physician member of a utilization review committee would not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

Physician Treatment Plan for Speech Pathology Services (Section 16)

The bill would repeal the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services.

The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished.

Since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services. As a result, your committee believes that the requirement that the physician establish a plan of treatment should be eliminated so as to conform medicare law and related program policy to actual practice among the professions. The requirement for physician referral and periodic physician review of the plan of treatment would be retained.

Payment for Physicians' Services Where Beneficiary Has Died (Section 17)

The bill would authorize medicare reimbursement for physicians' services rendered to a medicare patient before his death, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physician's services.

Under present law, a beneficiary who has received physician services which are reimbursable under medicare can either; (1) Send medicare an itemized bill, whether paid or unpaid, and be reimbursed directly by the program, or (2) assign the right to receive payment to the physician who provided the service. Where a beneficiary dies before he has executed an assignment of the bill, payment may be made directly to the physician only if he agrees to accept the medicare-determined reasonable charge as payment in full. (He may collect from the beneficiary only the applicable deductible and coinsurance amounts.) If the physician does not agree to this procedure, present law authorizes medicare reimbursement to the estate or the survivors of the deceased beneficiary, but only if the bill has been paid.

Your committee believes that the requirement that the physician's bill must be paid (where the assignment method is rejected by the physician) before medicare can make reimbursement often represents a significant financial burden for survivors of the deceased beneficiary. Thus, in cases where a physician does not agree to accept assignment on a claim for payment of services furnished to a deceased beneficiary, your committee's bill would allow payment on the basis of an unpaid bill. Payment would be made only to an individual who presents evidence that he has assumed the legal obligation to pay for the physician's services.

Presumed Coverage Provisions (Section 18)

The bill would repeal existing medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Protection against retroactive denials would continue to be afforded by general waiver of liability provision.

The 1972 social security amendments directed the Secretary to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption they would be covered by medicare.

A number of skilled nursing facilities and home health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. The regulations implementing this provision also have created complex administrative procedures to be followed by both the providers and the program. In addition, as a result of other, more effective, waiver of liability provisions included in the same 1972 legislation, the presumed coverage provisions are rarely used. Your committee notes that, according to HEW statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent far less than one-half of one percent of all claims for payment filed by these providers.

It is your committee's belief that the more general waiver of liability provision contained in section 1879 of the Social Security Act provides a more appropriate mechanism for addressing the type of situation intended to be covered under the presumed coverage provisions. As a result, your committee's bill repeals the presumed coverage provisions.

It is your committee's intention that since the general waiver of liability provision is to be used in all cases in this area, its rules are to be applied flexibly so as not to work undue hardship in cases which had been covered under the presumed coverage approach. In particular, it is intended that care be used in the application of rigid percentage limitations with respect to acceptable denial rates. This is particularly true in the case of those providers of service that have very small numbers of medicare beneficiaries where a denial in one or two cases might have the effect—through strict application of a percentage formula—of denying access to the favorable presumptions embodied in the provision.

Payment to Providers of Services (Section 19)

The bill would repeal the existing provisions of the medicare law under which payments to a provider of services are limited to the provider's customary charges if these charges are lower than reasonable costs.

Also, medicare reimbursement to providers of services under part B would be based on reasonable cost minus the coinsurance amounts providers could charge beneficiaries.

Although medicare providers of services are generally reimbursed, under present law, on the basis of reasonable costs, the amount of payment is limited to the lesser of the reasonable cost of covered services or the provider's customary charges to the public for such services. A variation of this rule applies to "public" (i.e., governmental) providers of services who render services free of charge or at nominal charges to the public; such providers are reimbursed, pursuant to regulations of the Secretary, on a basis that provides fair compensation. The rationale for this lower of costs or charges provision was that it would be inequitable for medicare to pay more for services than the provider charges the general public. However, despite an elaborate set of rules to avoid harsh treatment of certain providers, situations have arisen in which there is a question whether it is good public policy to reduce reimbursement, as this provision requires, to levels below cost—for example, in the case of Easter Seal rehabilitation agencies and community-supported home health agencies. Accordingly, the Subcommittee bill would repeal the lower of costs or charges provision.

Under another provision of present law, providers of services are paid 80 percent of the reasonable cost for services covered under medicare part B. Providers are authorized to charge beneficiaries a coinsurance amount equal to 20 percent of the reasonable charges (not in excess of their customary charges) for the services in question. The medicare reimbursement amount and the coinsurance amount are determined without reference to each other. Together, they sometimes produce income to the provider in excess of 100 percent of the reasonable cost. This result would be avoided under your committee's bill, which provides for payment of the reasonable cost minus the coinsurance amounts the provider may charge to the extent this does not exceed 80 percent of the reasonable cost.

Limit on Premium Increases Due to Late Enrollment (Section 20)

The bill would modify the existing provisions that require premiums for medicare part B (and for optional part A coverage) to be increased by ten percent for each year the beneficiary could have been but was not enrolled by limiting the premium increase to a maximum of 30 percent.

Under present law, if an individual fails to enroll timely in medicare's medical insurance plan (part B), the otherwise applicable premium amount is increased by 10 percent for each 12 months elapsing between the time he could have enrolled and actually did enroll. A similar premium increase is charged to uninsured persons who do not enroll timely in the hospital insurance plan (part A). There is no limit on the percentage amount the part A or part B premium can be increased due to late enrollment. The purpose of these provisions was to avoid the adverse selection that might occur if substantial numbers of healthy persons delayed enrollment until they were well past age 65 and became ill.

Most people, your committee has found, who enroll late do so, not because their health has deteriorated, but for a variety of reasons not related to health. For example, many aged beneficiaries mistakenly believe they have to retire from work before they can enroll and thus

enroll long after their initial enrollment period. Others, who are residing outside the country and cannot benefit from part B because of the exclusion of foreign medical care, enroll only upon their return to the United States. Still others decide not to enroll initially because they are covered under their employers' or their spouses' health plan. In many of these cases, the increased premium due to late enrollment could be considerably higher than the expected increase in program costs resulting from late enrollment and, in some cases, could produce a total premium that is prohibitive to persons living on reduced retirement income. The committee bill establishes a 30 percent limit on the amount by which parts A and B premiums can be increased due to late enrollment. Such a limit should keep the premium within more affordable reach and yet deter such adverse selection as might still occur.

Reenrollment in Part B (Section 21)

The bill would repeal the provision of existing law that permits an individual to reenroll in part B only once.

Under present law, an individual is permitted to reenroll in part B of the program only once; that is, if he disenrolls twice he is permanently barred from participation in the program. While the original purpose of this provision was to prevent the adverse selection that could occur if individuals were permitted to enroll and disenroll at will whenever there was a change in their health condition, your committee has found that beneficiaries do not as a rule disenroll from the program without good reason. But, there have been instances in which individuals through misunderstanding or inadvertence, have barred themselves from the program. Accordingly, your committee's bill allows unlimited reenrollment in part B while retaining the present provision relating to the time of the annual open enrollment period. Elimination of this part B requirement would also allow unlimited reenrollment under part A.

Chiropractors' Services (Section 22)

The bill would modify the requirement for chiropractic coverage so that a subluxation could be demonstrated to exist either through x-ray or other chiropractic clinical findings. Neither the x-ray nor other clinical procedures used by the chiropractor would be covered by medicare.

Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation (partial dislocation) by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by x-ray; however, the cost of the x-ray is not covered when performed by a chiropractor.

The x-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an x-ray. The General Accounting Office has indicated that the extent to which x-rays play a part in claims denial is not known. Although chiropractors must have x-rays available upon request, the x-ray is actually reviewed by medicare carriers in only a small number of cases.

Your committee believes that the requirement for an x-ray to demonstrate the subluxation of the spine is not necessary in every case,

is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take x-rays in every case to diagnose subluxation of the spine, your committee has concluded that it is inappropriate to require x-rays, with their accompanying radiation risks, for administrative purposes. Your committee is also concerned that although the x-ray is currently required in all cases, the beneficiary must bear the cost of the x-ray.

For these reasons, the bill provides that the presence of a subluxation could be demonstrated either by x-ray or by other chiropractice clinical findings.

Psychologists' Services (Section 23)

The bill would cover services furnished by a qualified licensed clinical psychologist to hospital inpatients where their stay is covered under part A of medicare. The services furnished by psychologists would be reimbursed on the basis of the reasonable charge for the service.

Under present law, services provided by psychologists to hospital inpatients either as employees of the hospital or under arrangements with the hospital are presently covered under part A of medicare as a hospital service. Hospital services, in general, are subject to the initial deductible (currently $144) and coinsurance after the 60th day; there is no deductible or coinsurance specifically applicable to the services provided by a psychologist. Services furnished to hospital inpatients by independently practicing phychologists are not covered under medicare unless they are for diagnostic services and they have been ordered by a physician.

Your committee's bill provides that, as an alternative to being reimbursed under part A as services furnished by hospital employees or services furnished under an arrangement, psychologists services may be reimbursed as part B services. The psychologist could bill the program or the beneficiary for inpatient services on the basis of his charge for the services furnished. The services furnished by the psychologist would be subject to the part B deductible and coinsurance.

The bill defines a qualified clinical psychologist as one who is licensed in the state (or in a state which does not license clinical psychologists, is legally authorized to perform the series of a clinical psychologist) and meets such other requirements determined necessary by the Secretary. It is your committee's intention that a qualified clinical psychologist would be further defined by the Secretary as one who has a doctorate degree in psychology and has had at least two years of supervised clinical experience, or who has a comparable combination of education and clinical experience. In addition, your committee expects the Secretary to designate further what specialty training within the various areas of applied psychology would be appropriate for providing therapeutic services to medicare beneficiaries.

Demonstration Project for Services of Clinical Social Workers (Section 24)

Services furnished by clinical social workers are presently covered when furnished to inpatients of hospitals and skilled nursing facilities or as home health services for those who are otherwise eligible for

home health benefits and under part B of medicare when furnished incident to a physician's service. Clinical social workers' services would also, under the provisions of your committee's bill, be covered when furnished in a community mental health center.

It is generally recognized that clinical social workers can provide services under a variety of circumstances that are directly beneficial to aged and disabled beneficiaries. Although services furnished by clinical social workers are presently covered under medicare in various organized settings, your committee believes it would be appropriate for the Secretary to conduct a demonstration project to determine in what other settings and under what other circumstances clinical social workers' services should be made available to medicare beneficiaries. The Secretary is to submit to the Congress, no later than 24 months after enactment, a detailed report on the demonstration project and any recommendations or legislative changes the Secretary finds desirable as a result of the demonstration project.

Residence in an Institution and Its Effect on Coverage of Durable Medical Equipment and Spell of Illness

Your committee believes that there is a critical need for a more discriminating interpretation of existing law in order to avoid inappropriately denying coverage for durable medical equipment to beneficiaries living in residential institutions. Where a legitimate question exists as to the primary purpose of an institution, it is essential to apply more selective criteria than nurse-patient ratios in order to realistically distinguish between skilled nursing and residential facilities. Your committee is concerned about the fact that the failure to apply such criteria, even though such an approach was intended under present law, has resulted in some cases in the inappropriate denial of coverage for durable medical equipment obtained by beneficiaries living in residential facilities. It is expected, therefore, that the Secretary will promptly develop and utilize appropriate additional criteria in making such determinations. It is not intended, however, that current policies relating to reimbursement to durable medical equipment suppliers be changed. On the contrary, it is expected that the Secretary will continue to apply in medicare the policies that residential facilities cannot be reimbursed as suppliers of durable medical equipment, and that payment to suppliers will be made only for such equipment as is not ordinarily maintained or provided for the use of its occupants by such facilities.

Your committee is also concerned about the predicament of beneficiaries who exhaust their benefits because they are unable to start a new spell of illness as long as they are residing in an institution that provides some skilled nursing care.

The committee expects the Secretary to make a comprehensive reassessment of possible solution to this problem. This study should also take into account the relationship between medicare criteria for qualification as a skilled nursing facility and state licensure personnel requirements for various types of nursing and domiciliary facilities. Your committee expects the Secretary to submit the results of this study and any legislative recommendations he determines are appropriate to the Congress.

Ambulance Services

Section 1861(s)(7) of the Social Security Act relating to ambulance services states only that such services are covered "where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations." Your committee's report on the legislation that established the medicare program in 1965 stated that the intent was to provide a limited ambulance benefit, and the report was specific that the only transportation to be covered is to a hospital or skilled nursing facility and back to a patient's home. In addition, the transportation to a hospital was restricted by the report language to transportation to the nearest hospital with "appropriate facilities."

Such language has been interpreted to mean that the availability of a physician is not a consideration in determining whether a hospital has appropriate facilities. Occasionally, the nearest hospital, while adequately equipped, does not have a physician to provide the necessary service—for example, no neurosurgeon when neurosurgery is required. In such cases, medicare payment for the ambulance transportation has been limited to the amount that would have been paid had the patient been transported to the nearest hospital with appropriate facilities, even though the patient must in fact be transported to another, more distant, facility to obtain the necessary services.

It is your committee's intention that the statutory language in 1861(s)(7) be interpreted so as to also include ambulance service to a more distant hospital where the nearer hospital does not have appropriate medical staff. This will greatly benefit beneficiaries who must now be transported to the more distant facility at their own expense.

The committee has found other instances in which hospital or skilled nursing facility patients or patients confined to their homes require ambulance transportation to and from radiological services which are in a nonhospital-affiliated outpatient setting—that is, a freestanding radiological center or a physician's office. For example, a hospital may use the radiological equipment in a nearby freestanding radiological center rather than purchase its own. But since the setting is not part of a hospital, the ambulance transportation to the freestanding center is not covered.

Your committee believes that ambulance services furnished in a freestanding radiological setting should be covered so as to eliminate the illogical situation where the program must pay to have the patient transported to a more distant radiological service which is part of a hospital when a more convenient facility is available. This change is also intended to eliminate the situation where the beneficiary is transported to a freestanding setting but must pay for the ambulance service out of his own pocket. Such a benefit expansion will be safeguarded against possible overutilization by covering such ambulance transportation to a freestanding facility only where: (i) Other methods of transportation are not medically appropriate; (ii) the service is not available in the hospital where the beneficiary is an inpatient—if he is an inpatient—or in a hospital in the locality; (iii) the service for which the beneficiary is being transported is a covered service; and (iv) where a State provides for such approval, the radiological service is approved by the State health planning and development agency.

IV. COST OF CARRYING OUT THE BILL AND EFFECT ON THE REVENUES

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, your committee states that the Health Care Financing Administration's Office of Financial and Actuarial Analysis (Department of Health, Education, and Welfare) has supplied the committee with the following 5-year estimate of the cost and revenue impact of this legislation:

COST ESTIMATE

[By fiscal years; in millions of dollars]

Section		1979	1980	1981	1982	1983
	OUTLAYS					
2	Home health	$11	$14	$16	$18	$21
3	Disability waiting period	23	27	32	37	42
4	Coverage outside the United States	0	0	(1)	(1)	(1)
5	Dentists' services	12	14	15	16	18
6	Treatment of plantar warts	2	2	2	2	2
7	Community mental health centers	10	50	60	70	80
8	Outpatient rehabilitation	4	10	11	13	15
9	Optometrists' services	1	1	1	1	1
10	Hospice services demonstration	(2)	(2)	(2)		
11	Orthopedic shoe study	0	0			
12	Antigens	(2)	(2)	(2)	(2)	(2)
13	Beneficiary not at fault	(2)	(2)	(2)	(2)	(2)
14	Rural hospital standards	0	0	0	0	0
15	Podiatrists' certification	0	0	0	0	0
16	Speech pathology	0	0	0	0	0
17	Payment where beneficiary has died	0	0	0	0	0
18	Repeal of presumed coverage	0	0	0	0	0
19	Payment to providers of services	−2	−6	−7	−8	−10
20	Late enrollment	6	7	8	9	10
21	Part B—Reenrollment	(2)	(2)	(2)	(2)	(2)
22	Chiropractors	24	26	28	30	33
23	Inpatient psychologists' services	3	4	6	8	10
24	Clinical social worker demonstration	(2)	(2)			
	Ambulance services	1	1	1	1	1
	Durable medical equipment	(1)	(1)	(1)	(1)	(1)
	Total outlays	95	150	173	197	223
	BUDGET AUTHORITY [3]					
20	Part B—Late enrollment	+4	+5	+7	+7	+9

[1] Estimate not available.
[2] Negligible costs or savings.
[3] Includes both premium income and general revenue transfer.

Your committee concurs with the Department's estimate.

In compliance with subdivision (C) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Congressional Budget Office has informed your committee that it has reviewed the estimates (as well as the method of derivation) made by the Office of Financial and Actuarial Analysis and, on a preliminary basis, finds them acceptable.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE HOUSE RULES

Vote of the Committee

In compliance with subdivision (B) of clause 2(l)(2) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the committee on the motion to report the bill, as amended. The bill, H.R. 13097, as amended, was ordered favorably reported by a voice vote.

Oversight Findings

In compliance with subdivision (A) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the following statement is made relative to oversight findings by your committee.

Your committee, in its ongoing review of the operation of the medicare program, has conducted a number of hearings over the past few years to determine the adequacy of the benefit structure as well as the administration of the program. In September, 1975, your committee's Subcommittee on Health held hearings on selected medicare issues; in 1976, hearings were held on several medicare proposals recommended by the President; and in 1977, field hearings were conducted in Cincinnati and Cleveland, Ohio, on health care services under the medicare program. Additionally, during various hearings on national health insurance, both in Washington, D.C. and around the country, testimony was heard by the Health Subcommittee on the need to improve the medicare program. Many areas of the medicare law which need improvement have also been brought to your committee's attention through correspondence from concerned beneficiaries.

In 1976, your committee's Subcommittees on Health and Oversight announced a major study of home health services under the medicare program designed to eliminate uncertainty about the nature and extent of abuses and to provide the data necessary to permit your committee to more effectively evaluate legislative proposals for changes in and expansion of the home health benefit. On September 13, 1976, these two subcommittees conducted a hearing on excessive or unnecessary services, the billing of excessive costs to the medicare program and the existence of certain questionable competitive practices of some home health providers. On March 8 and 9, 1977, your Health and Oversight Subcommittees also held hearings jointly with the Senate Special Committee on Aging to examine issues related to the fiscal integrity of home health programs under the Social Security Act. In August of this year, your Subcommittee on Oversight continued its investigations of medicare abuses in the home health industry. Although many of the abusive practices that were uncovered

during these investigations have been addressed in P.L. 95–142, the medicare-medicaid anti-fraud and abuse bill, these hearings were also helpful to your committee in addressing in this legislation the issues of standards and reimbursement guidelines to insure the effective administration of the home health benefit.

New Budgetary Authority and Tax Expenditures

With respect to subdivision (B) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in present law by this bill involve no new or increased tax expenditures. With respect to new budget authority, section 20 of the bill, which places a limit on increases in the medicare premium due to late enrollment, might result in some slight increase in the number of beneficiaries who elect to enroll. To the extent that there are such additional enrollees, there will be added premium income to the part B trust fund. This slight increase in premium income to the trust fund would be considered new budget authority for purposes of the budget act.

Oversight by Committee on Government Operations

With respect to subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, your committee advises that no oversight findings or recommendations have been submitted to your committee by the House Committee on Government Operations with respect to the subject matter contained in the bill.

Inflationary Impact

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in existing law by this bill would have a negligible inflationary impact on prices and costs in the operation of the national economy.

VI. SECTION-BY-SECTION ANALYSIS

SECTION 2. HOME HEALTH SERVICE

Section 2 of the bill amends the appropriate sections of title XVIII and title II of the Social Security Act and the Railroad Retirement Act of 1974 to eliminate the three-day prior hospitalization requirement under part A of medicare; the present limitation on the number of visits available under parts A and B; and the part B $60 deductible with respect to home health services. These amendments are effective with respect to services furnished on or after July 1, 1979. Sections 1814(a) and 1835(a) are amended by adding a new sentence at the end thereof to require that the physician who performs the certification for home health services and establishes the plan of treatment could not have a significant ownership interest in, or a significant financial or contractual relationship with, the home health agency providing the services. Section 1861(m)(4) of the Social Security Act is amended to provide that the home health aide services covered as a home health service must be furnished by a home health aide who has successfully completed a training program approved by the Secretary. Section 1861(o) is amended to provide that proprietary home health agencies shall be subject to the same licensing requirements as nonprofit home health agencies and shall no longer be required to meet additional standards and requirements. Section 1861(o) is also amended by adding a new paragraph (7) to provide that a home health agency, for the purpose of participation in the medicare program, is one which meets such additional requirements as the Secretary finds necessary for the effective and efficient operation of the program. Section 1816(e) is amended by adding a new paragraph (4) which directs the Secretary to designate regional agencies or organizations to serve as intermediaries for home health agencies in that region.

The amendments relating to physician certification and training for home health aides are effective with respect to services furnished on or after July 1, 1979. The amendments directing the Secretary to designate regional intermediaries, eliminating the present additional requirements for proprietary home health agencies and providing authority for additional standards for home health agencies are effective immediately, except that the Secretary is directed to take administrative action to assure that improvements, in accordance with the authority to establish additional standards, will be made with respect to home health services by June 30, 1979.

SECTION 3. ELIMINATION OF SECOND WAITING PERIOD FOR RE-ENTITLED DISABILITY BENEFICIARIES

Section 3(a) of the bill strikes out the word "consecutive" at various points in the Social Security Act and the Railroad Retirement Act of 1974, thus modifying the requirement of existing law that an individual who is entitled to monthly social security or railroad retirement benefits on account of his disability must have been entitled to such

benefits for 24 consecutive months before he becomes entitled to medicare; under the bill, the months in the 24-month medicare waiting period need not be consecutive. As a result of this change, an individual who becomes reentitled to monthly disability benefits can count toward his 24-month medicare waiting period the months during which he was previously entitled to such monthly benefits; if he already had met the 24-month requirement, he could qualify for medicare without a new waiting period.

Section 3(b) amends section 226 of the Social Security Act by redesignating subsection (f) as subsection (g) and inserting a new subsection (f) which provides that, in determining whether the 24-month waiting period has been met with respect to a particular month, the previous months for which an individual was entitled to monthly disability benefits may be counted toward the 24-month requirement only if the previous period of such entitlement did not end more than 60 months (or, in certain cases 84 months) previously. This conforms the waiting period provisions for medicare to those for monthly social security disability benefits; only where an individual becomes reentitled to monthly disability benefits without a new waiting period may he count toward satisfaction of the medicare requirement months in the period during which he was previously entitled to monthly disability benefits.

Section 3(c) provides that the amendments made by this section shall apply with respect to medicare benefits for months after the month of enactment.

SECTION 4. RECIPROCAL AGREEMENTS FOR SERVICES FURNISHED OUTSIDE THE UNITED STATES

Section 4 of the bill amends title XVIII of the Social Security Act by adding at the end thereof a new section 1882 entitled "International Agreements."

The new section 1882 (a) and (b) authorizes the President to enter into agreements establishing reciprocal arrangements between medicare and the comparable or similar program of any foreign country. Any such agreement must specify (1) the nature and extent of payment to be made to or on behalf of entitled individuals; (2) the nature and duration of services for which payment will be made (except that no agreement may authorize any foreign national to receive benefits in the United States on a reciprocal basis in excess of those provided for medicare beneficiaries); (3) such limitations on entitlement of individuals to benefits on a reciprocal basis as the President deems appropriate (except that no agreement may provide entitlement to benefits for a foreign national who does not meet medicare's entitlement requirements with respect to age or medical condition); (4) the methods by which the cost of providing services to entitled individuals will be shared by the individuals receiving the services and the respective programs of the United States and the foreign country; and (5) such other provisions, not inconsistent with this section, as the President deems appropriate.

New section 1882(c) authorizes the Secretary of Health, Education, and Welfare to promulgate such regulations and establish such procedures as are reasonable and necessary to implement and administer any agreement entered into under this section.

New section 1882(d) authorizes the Secretary, pending the conclusion of an agreement under this section, to enter into interim arrangements with any hospital in that country which is accredited by the Joint Commission on Accreditation of Hospitals, or such other hospitals as the Secretary finds meet health and safety standards equivalent to those required by medicare in the United States and which are accredited in the foreign country concerned, under which payment may be made for inpatient hospital services (as defined in section 1861 of the Social Security Act) to or on behalf of medicare beneficiaries. For purposes of making such payment, the Secretary may use any method provided for in section 1814(f) of the Social Security Act, except that such payment shall be reduced to the extent the individual has no legal obligation to pay for the services by reason of the laws of the foreign country in which the hospital is located, or such individual's membership in an insurance plan provides for payment for such services.

SECTION 5. DENTISTS' SERVICES

Section 5(a) of the bill amends the present definition of physician in section 1861(r)(2) of the Social Security Act to provide that services performed by a doctor of dental surgery or of dental medicine are covered where such services are covered when performed by a physician as defined in section 1861(r)(1) provided the doctor of dental surgery or of dental medicine is legally authorized to practice dentistry by the State in which he performs such functions and he is acting within the scope of his license.

Section 5(b) amends section 1814(a)(2)(E) of the Social Security Act to provide coverage for inpatient hospital services for the performance of a noncovered dental service where a physician (including a physician as defined in 1861(r)(2)) certifies that not only a patient's underlying medical condition and clinical status but also the severity of the dental procedure itself warrants hospitalization.

Section 5(c) amends section 1862(a)(12) of the Social Security Act by providing that hospital services for the performance of a noncovered dental procedure are not excluded services where the severity of the dental procedure warrants hospitalization.

SECTION 6. TREATMENT OF PLANTAR WARTS

Section 6 of the bill amends section 1862(a)(13)(C) of the Social Security Act to eliminate warts from the definition of the routine foot care that is excluded as a covered service.

SECTION 7. COMMUNITY MENTAL HEALTH CENTERS

Section 7 (a), (b) and (c) of the bill amends section 1812 of the Social Security Act to provide that payment may be made for community mental health center services under part A of title XVIII of the Social Security Act for (1) up to 10 outpatient visits (as defined by the Secretary) during a calendar year, and for (2) up to 60 partial hospitalization visits (as defined by the Secretary) during a calendar year, if, with respect to such partial hospitalization visits, the beneficiary has not exceeded the 190-day lifetime limitation on inpatient psychiatric hospital services. In determining an individual's 190-day lifetime limitation, the Secretary shall include 1 day for every 4 partial hospitalization visits to a community mental health center by such individual.

Section 7(d) of the bill amends section 1814(a)(2) of the Social Security Act to provide that in the case of community mental health center services payment may be made only if a physician certifies that (1) such services are or were medically necessary, (2) a plan for such services has been established by a physician or other mental health professional (as defined for this purpose by the Secretary) and is periodically reviewed and approved by a physician, (3) such services were furnished while the individual is or was under the care of a physician, and (4) with respect to a partial hospitalization visit, the individual would have otherwise required (in the physician's judgment) inpatient psychiatric services.

Section 7(e) of the bill amends section 1814(a) of the Social Security Act to require that, in connection with partial hospitalization visits, the center obtains a statement from the beneficiary indicating that he understands that 4 partial hospitalization visits will reduce by one day the number of inpatient psychiatric hospital days to which he is entitled during his lifetime.

Section 7(f) of the bill amends section 1814(b) of the Social Security Act, as amended by section 19 of the bill, to provide that reimbursement for community mental health center services shall be made on the basis of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A) of the Social Security Act.

Section 7(g) of the bill amends section 1861(*l*) of the Social Security Act, which defines the conditions for an acceptable transfer agreement between a hospital and a skilled nursing facility, to provide that the same conditions apply to a transfer agreement between a hospital and a community mental health center.

Section 7(i) of the bill amends section 1861(w)(1) of the Social Security Act to provide that, with respect to community mental health "provider of services."

Section 7(i) of the bill amends section 1861(w) of the Social Security Act to provide that, with respect to community mental health centers, the term "arrangements" is limited to arrangements under which receipt of payment by the center for services for which a beneficiary is entitled to have payment made under title XVIII of the Social Security Act, discharges the liability of the beneficiary or any other person to pay for the services.

Section 7(j) of the bill amends section 1861 of the Social Security Act by adding at the end thereof a new subsection (bb) entitled "Community Mental Health Center Services." The new subsection (bb)(1) defines "community mental health center services" as (A) active diagnostic and therapeutic services furnished by qualified mental health professionals; (B) drugs and biologicals which cannot be self-administered; and (C) such items and supplies as are ordinarily furnished to outpatients by centers in connection with an active program of diagnosis and treatment, excluding, however, any item or service if it would not be covered if furnished to an inpatient of a hospital.

New subsection (bb)(2) defines a "community mental health center" as a facility which (A) meets the definition of a center under section 201 of the Community Mental Health Center Act; (B) is primarily engaged in providing outpatient mental health services; (C)

has a requirement that all mental health services are provided under a physician's supervision; (D) meets requirements relating to qualifications of the staff; (E) maintains clinical records on all patients; (F) has a utilization review plan in accordance with regulations; (G) has a transfer agreement with a hospital pursuant to subsection (l); (H) is licensed under State law (where applicable); (I) has appropriate procedures for storing, dispensing and administering drugs and biologicals; and (J) meets such other health and safety conditions as may be prescribed in regulations.

Section 7(k) of the bill amends section 1832 (a)(2)(B)(i) of the Social Security Act to provide that payment would be made to the community mental health center for services furnished by a physician to a patient in a community mental health center.

Section 7(l) of the bill amends section 1864(a) of the Social Security Act to provide for agreements with State agencies for the purposes of determining whether a facility is a community mental health center as defined in new section 1862(bb)(2) of the bill.

Section 7(m) and (n) of the bill makes conforming amendments in section 226(c)(1) of the Social Security Act and section 7(d)(1) of the Railroad Retirement Act of 1974.

Section 7(o) of the bill provides that the amendments made by this section are effective with respect to a community mental health center's first accounting period which begins on or after March 1, 1979.

SECTION 8. COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES

Subsections (a) and (b) of section 8 of the bill amend section 1832 (a) of the Social Security Act to include comprehensive outpatient rehabilitation services among the medical and other health services for which payment may be made under medicare part B on behalf of an entitled beneficiary.

Section 8(c) adds to section 1835(a)(2) of the Social Security Act a new subparagraph (E) requiring as a condition of payment for comprehensive outpatient rehabilitation services that a physician certify that the services were required because the individual needed skilled rehabilitation services, a plan for furnishing such services has been established and is periodically reviewed by a physician, and the services were furnished while the individual was under the care of a physician.

Section 8(d) amends section 1861(u) of the Social Security Act to include comprehensive outpatient rehabilitation facilities within medicare's definition of a provider of services.

Section 8(e) amends section 1861(z) of such Act to require a comprehensive outpatient rehabilitation facility to have an overall plan and budget as described therein.

Section 8(f) adds to section 1861 of the Social Security Act a new section (cc) relating to comprehensive outpatient rehabilitation services and facilities.

Paragraph (1) of new subsection (cc) defines the term "comprehensive outpatient rehabilitation services" as including the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations) to an outpatient of the facility under a plan established and periodically reviewed by a physician: physicians' services; physical therapy, occupational therapy,

speech pathology services, and respiratory therapy; prosthetic and orthotic devices including testing, fitting, and training in their use; social and psychological services; nursing care by or under the supervision of a registered professional nurse; drugs and biologicals which cannot be self-administered; supplies, appliances and equipment; and such other medically necessary items and services for rehabilitation of the patient as are ordinarily furnished by such facilities. However, items and services would be excluded if they would not be covered when furnished to a hospital outpatient.

Paragraph (2) of the new subsection (cc) defines the term "comprehensive outpatient rehabilitation facility" as a public or private institution which: is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons; provides at least physicians' services (by physicians who are available at the facility on a full- or part-time basis), physical therapy, and social or psychological services; maintains clinical records on all patients; has policies established by a professional group including one or more physicians and provides for them to be carried out by a full- or part-time physician associated with the facility; requires that every patient be under the care of a physician; is licensed or meets State or local licensing requirements; has in effect a utilization review plan; has in effect an overall plan and budget that meets the requirements of section 1861(z); and meets such other health and safety conditions as the Secretary may find necessary, including conditions concerning qualifications of personnel. In the case of those outpatient rehabilitation centers which have a physician available only on a part-time basis, it is expected that the physician would be available in the center a substantial part of the time the center is open.

Section 8(g) amends section 1863 of the Social Security Act to require that, as in the case of other providers, the Secretary of HEW shall, in developing health and safety conditions for comprehensive outpatient rehabilitation facilities, consult with specified governmental and private organizations, and to provide that such conditions may be varied for different areas or different classes of facilities and may, at the request of a State, be higher for such State than for other States.

Section 8(h) amends section 1864(a) of the Social Security Act to make provision for the use of State agencies to determine compliance with the conditions of participation for comprehensive outpatient rehabilitation facilities.

Section 8(i) provides that the amendments made by section 8 of the bill shall become effective with respect to a comprehensive outpatient rehabilitation facility's first accounting period which begins on or after March 1, 1979.

SECTION 9. OPTOMETRISTS' SERVICES

Section 9(a) of the bill amends the definition of physician in 1861(r)(4) of the Social Security Act to provide coverage for services furnished by optometrists related to the treatment of aphakia.

Section 9(b) directs the Secretary to submit to the Congress by June 1, 1979, legislative recommendations with respect to medicare reimbursement for services furnished by optometrists in connection with the treatment of cataracts and with respect to such other services as they are legally authorized to perform.

SECTION 10. DEMONSTRATION PROJECTS FOR HOSPICE SERVICES

Section 10(a) of the bill directs the Secretary to carry out demonstration projects, as authorized in accordance with section 222 of Public Law 92–603, to permit reimbursement under title XVIII of the Social Security Act for services performed by hospices offering comprehensive health services.

Section 10(b) of the bill stipulates that the projects should permit the Secretary to evaluate (1) the types of services and levels of care provided by hospices in various settings; (2) whether hospice services in various settings are an alternative to traditional services or an additional set of services; (3) the costs of hospice services; (4) the appropriate standards for assuring quality of care; and (5) mechanisms for utilization control.

Section 10(c) of the bill directs the Secretary to submit to the Congress, no later than January 1, 1981, a report on the demonstration projects conducted under subsection (b), and any legislative recommendations for changes in title XVIII of the Social Security Act which he finds necessary or desirable as a result of such demonstration projects.

SECTION 11. STUDY OF COVERAGE FOR ORTHOPEDIC SHOES

Section 11 of the bill directs the Secretary, in consultation with appropriate professional organizations, to conduct a study of methods for providing coverage under part B of title XVIII of the Social Security Act for orthopedic shoes for individuals with disabling or deforming conditions who require special fitting considerations to help protect against increasing disability or serious medical complications or who require special shoes in conjunction with the use of an orthosis or foot support. The Secretary is required to report to the Congress, no later than January 1, 1980, on the findings of this study and such legislative recommendations as he finds appropriate with respect to utilization, cost control, quality of care, and equitable and efficient administration of such an extension of coverage.

SECTION 12. ANTIGENS

Section 12 of the bill amends section 1861(s)(2) of the Social Security Act by adding a new subparagraph (G) to provide coverage for antigens prepared by a physician, for a particular patient, including antigens which are forwarded to another qualified person (including a rural health clinic) for administration to such patient from time to time, by or under the supervision of another physician.

SECTION 13. PAYMENT WHERE BENEFICIARY NOT AT FAULT

Section 13 of the bill amends section 1879 of the Social Security Act by adding at the end thereof a new subsection (e). New subsection (e) provides that where payment for inpatient hospital services or extended care services may not be made under part A of title XVIII of the Social Security Act on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertant, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861(e) or (j) of the Social Security Act by such provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary may take such ac-

tion with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertant, or erroneous action.

SECTION 14. FLEXIBILITY IN APPLICATION OF STANDARDS TO RURAL HOSPITALS

Section 14 of the bill amends section 1861(e) of the Social Security Act (which defines a hospital for medicare purposes) by adding a new sentence at the end thereof, which sentence provides that the term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area specified in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—(A) with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may temporarily waive the requirements for such period as he deems appropriate where (i) there is a temporary shortage of qualified nursing personnel in the area, (ii) a registered nurse is rendering or supervising the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during the temporary period will not adversely affect patient health and safety; (B) with respect to health and safety requirements promulgated under paragraph (9) of this subsection, such requirements are to be applied in such manner as to assure that personnel requirements take into account the availability of technical personnel in the area and the scope of services rendered by the facility, and the Secretary is to provide for the continued participation of such a rural facility where the personnel requirements are not fully met, for such period as he determines that the facility is making good faith efforts to fully comply with the personnel requirements and the employment of such personnel as are available to the facility will not adversely affect patient health and safety; and (C) with respect to fire and safety requirements promulgated under paragraph (9) of this subsection, the Secretary may (i) waive (for such period as he deems appropriate) specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for the facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9) if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

SECTION 15. CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS

Section 15(a) of the bill amends section 1861(r) of the Social Security Act (which defines the term "physician" for purposes of medicare) by modifying the definition in paragraph (3), relating to podiatrists. For purposes of medicare coverage, a doctor of podiatry or surgical chiropody is a physician with respect to functions he is legally authorized to perform as such by the State in which he performs them. In addition, a podiatrist is defined as a physician for purposes of sections 1814(a) and 1835 of the Social Security Act (relating to physician certifications) and subsections (k) (relating to utilization review) and (m) (relating to the requirement that a

home health patient be under the care of a physician) of section 1861; for such purposes, the definition extends only to functions that are consistent with the scope of podiatric practice in the State where the podiatrist performs them and that are consistent with the policies of any health care institution involved.

Section 15(b) amends section 1861(k)(2)(A) of the Social Security Act to provide that, although a podiatrist may serve as a physician member of a hospital or skilled nursing facility utilization review committee, such a committee must also have two physician members who are either doctors of medicine or doctors of osteopathy.

SECTION 16. PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY

Section 16 of the bill amends section 1835(a)(2)(D)(ii) of the Social Security Act to allow a physician or the speech pathologist providing the speech pathology services to establish the plan of treatment required by this section.

SECTION 17. PAYMENT FOR PHYSICIANS' SERVICES WHERE BENEFICIARY HAS DIED

Section 17 of the bill amends section 1870(f) of the Social Security Act to provide for reimbursement for physicians' services where the beneficiary has died, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physicians' services. Alternative procedures for payment contained in 1870(f) are retained under this charge.

SECTION 18. PRESUMED COVERAGE PROVISIONS

Section 18 of the bill repeals section 1814(h) and (i) of the Social Security Act pertaining to presumed coverage for certain care provided in skilled nursing facilities and certain care provided by home health agencies and redesignates the remaining subsection accordingly.

SECTION 19. PAYMENT TO PROVIDERS OF SERVICES

Section 19(a) of the bill amends section 1814(b) of the Social Security Act to provide that (except for reimbursement for services of community mental health centers and certain services to renal disease patients) medicare reimbursement under part A to providers of services will (subject to deductible and coinsurance provisions) be on the basis of reasonable cost as determined under section 1861(v) of the Social Security Act. Subsection (a) of the bill repeals the provisions of existing law under which payment to a provider is limited to the provider's customary charges if these charges are lower than reasonable costs.

Section 19(b) amends section 1833(a) of the Social Security Act (relating to reimbursement under part B) by striking out paragraphs (2) and (3) and inserting new paragraphs (2), (3) and (4).

New paragraph (2) provides (except for home health services, rural health clinic services and comprehensive outpatient rehabilitation services, and subject to any unsatisfied deductible amounts) for reimbursement to providers of services based on the reasonable costs of covered services (as determined under section 1861(v) of the Social Security Act) less any coinsurance amounts the provider is authorized to charge beneficiaries (as described in clause (ii) of section 1866(a)(2)(A)) but in no case may the amount reimbursed exceed 80 percent of the reasonable cost of the services. (The new paragraph also restates, without substantive change, the existing rules for reimburse-

ment to home health agencies and independently practicing physical therapists.)

In similar fashion, new paragraph (3) provides, with respect to rural health clinic and comprehensive outpatient rehabilitation services, for coinsurance amounts to be offset against costs; except that in the case of such clinics and facilities, the costs involved are amounts which are reasonable and related to the cost of furnishing covered services or based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A) of the Social Security Act.

New paragraph (4) provides for reimbursement of 100 percent of costs, as determined in accordance with section 1814(b)(2) of the Social Security Act, for physician services furnished in a community mental health center.

Section 19(c) of the bill amends section 1833(c) of the Social Security Act to provide that the limitation on payment for outpatient mental health services does not apply to services furnished to an individual as a patient of a community mental health center.

Section 19(d) of the bill provides that the amendments made by this section shall be effective with respect to services provided on or after January 1, 1979.

SECTION 20. LIMIT ON PREMIUM INCREASES DUE TO LATE ENROLLMENT

Section 20 of the bill amends section 1839(d) of the Social Security Act by limiting the premium increase for late enrollemnt provided for in the subsection to 30 percent.

SECTION 21. REENROLLMENT IN PART B

Section 21 of the bill repeals section 1837(b) of the Social Security Act which limited reenrollment in part B of the program.

SECTION 22. CHIROPRACTOR SERVICES

Section 22 of the bill amends section 1861(r)(5) of the Social Security Act to provide coverage for services furnished by chiropractors for manipulation of the spine where the existence of a subluxation of the spine can be demonstrated by an x-ray or other chiropractic clinical findings.

SECTION 23. INPATIENT PSYCHOLOGISTS' SERVICES

Section 23(a) of the bill amends section 1861(r) of the Social Security Act by adding a new clause (6) which includes in the definition of physician, clinical psychologists who are licensed by the state (or in a state which does not license clinical psychologists, are legally authorized to perform the services of a clinical psychologist) and who meet uniform standards prescribed by the Secretary, but only for the purpose of billing for services furnished to inpatients of a hospital where the patient's stay is covered under part A of medicare and only with respect to services which they are legally authorized by the state to perform.

Section 23(b) amends section 1861(b) of the Social Security Act by adding a new paragraph (8) to clarify that services furnished by a psychologist who is providing services to hospital inpatients as an employee or under an arrangement, can continue to be reimbursed under part A of medicare where a psychologist does not bill for such services under part B of medicare.

SECTION 24. DEMONSTRATION PROJECT FOR SERVICES OF CLINICAL SOCIAL WORKERS

Section 24(a) of the bill directs the Secretary to develop and carry out demonstration projects, as authorized in accordance with section 222 of Public Law 92–603, to determine the administrative, financial, and other aspects of making the services of clinical social workers more generally available as a benefit under title XVIII of the Social Security Act.

Section 24(b) directs the Secretary to submit to the Congress, no later than 24 months following the date of enactment of this Act, a detailed report on the demonstration project conducted under this section. Such report is to include any recommendations for legislative changes in title XVIII of the Social Security Act which the Secretary finds necessary or desirable as a result of carrying out such demonstration projects.

VII. Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

Social Security Act

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TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Sec. 226.

(a) * * *

(b) Every individual who—

(1) has not attained age 65, and

(2) (A) is entitled to, and has for 24 [consecutive] calendar months been entitled to, (i) disability insurance benefits under section 223 or (ii) child's insurance benefits under section 202(d) by reason of a disability (as defined in section 223(d)) or (iii) widow's insurance benefits under section 202(e) or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)), or (B) is, and has been for not less than 24 [consecutive] months a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth [consecutive] month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending with the month following the month in which notice

of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or earlier, with the month before the month in which he attains age 65.

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, *community mental health center services*, and [post-hospital] home health services (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services [or post-hospital home health services] unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

* * * * * * *

(f) For purposes of subsection (b) (and for purposes of section 1837(g)(1) of this Act and section 7(d)(2)(ii) of the Railroad Retirement Act of 1974), the 24 months for which an individual has to have been entitled to specified monthly benefits on the basis of disability in order to become entitled to hospital insurance benefits on such basis effective with any particular month (or to be deemed to have enrolled in the supplementary medical insurance program, on the basis of such entitlement, by reason of section 1837(f)), where such individual had been entitled to specified monthly benefits of the same type during a previous period which terminated—

(1) more than 60 months before that particular month in any case where such monthly benefits were of the type specified in clause (A)(i) or (B) of subsection (b), or

(2) more than 84 months before that particular month in any case where such monthly benefits were of the type specified in clause (A)(ii) or (A)(iii) of such subsection,

shall not include any month which occurred during such previous period.

[(f)] (g) For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital [and related post-hospital services], *related post-hospital, home health, and community mental health services* in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 [consecutive] months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; [and]

[(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.]

(3) home health services; and

(4) community mental health center services for—

(A) up to 10 outpatient visits (as defined by the Secretary) during a calendar year; and

(B) up to 60 partial hospitalization visits (as defined by the Secretary) during a calendar year.

* * * * * * *

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) in-

sofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)). *In determining the 190-day limit with respect to any individual under subsection (b)(3), the Secretary shall include 1 day for every 4 partial hospitalization visits to a community mental health center by such individual.*

[(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.]

(e) For purposes of subsections [(b), (c), and (d),] *(b) and (c)*, inpatient hospital services, inpatient psychiatric hospital services, [post-hospital extended care services, and post-hospital home health services] *and post-hospital extended care services* shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

(g) Payment under this part may be made for community mental health center services furnished an individual for only—

(1) up to 10 outpatient visits to such a center during any calendar year; and

(2) up to 60 partial hospitalization visits to such a center during any calendar year, if the individual has not exceeded the limitation on inpatient psychiatric hospital services described in subsection (b)(3).

Services shall be taken into account for purposes of paragraphs (1) and (2) and the second sentence of subsection (c) only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

* * * * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner,

and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of [post-hospital] home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy[, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which

would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services]; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; [or]

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status *or because of the severity of the dental procedure*, requires hospitalization in connection with the provision of such [dental] services; *or*

(*F*) *in the case of community mental health center services, (i) such services are or were medically necessary, (ii) a plan for furnishing such services has been established by a physician (as defined in section 1861(r)(1)) or other mental health professional (as defined for this purpose in regulations by the Secretary) and is periodically reviewed and approved by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, and (iv) in the case of services provided with respect to a partial hospitalization visit, the individual would otherwise require or have required (in the professional judgment of such physician) inpatient psychiatric services;*

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in

effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); [and]

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding [.]; *and*

(8) with respect to services furnished by a community mental health center in connection with a partial hospitalization visit, such center obtains a statement (pursuant to regulations prescribed by the Secretary), in writing and signed by the individual or his representative, indicating that the individual understands that 4 partial hospitalization visits will reduce by 1 day the number of days of inpatient psychiatric hospital services to which such individual is entitled during his lifetime under this part.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than June 30, 1979, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.*

Amount Paid to Providers

(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, [be—

[(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services; or

[(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regu-

lations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.] *be, except as provided by paragraph (2), the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B).*

(2) The amount paid with respect to community mental health center services shall be equal to the costs which are reasonable and related to the cost of providing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A).

No Payments to Federal Providers of Services

(c) Subject to section 1880, no payment may be made under this part (except under subsection (d) or subsection [(j)] *(h)*) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

* * * * * * *

[Payment for Pothospital Extended Care Services

[(h)(1) An individual shall be presumed to require the care specified in subsection (a)(2)(C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

[(A) the certification referred to in subsection (a)(2)(C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations,

[(C) such certification is accompanied by a plan of treatment for providing such services, and

[(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity; and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not

apply, after the effective date of such determination, in any case in which such a physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

[Payment for Posthospital Home Health Services

[(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

[(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

[(C) there is compliance with such other requirements and procedures may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be presecribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).]

PAYMENT FOR CERTAIN HOSPITAL SERVICES PROVIDED IN VETERANS' ADMINISTRATION HOSPITALS

[(j)](*h*)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on

which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

* * * * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * * * *

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may (*subject to the provisions of paragraph (4)*) designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a

hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(4) Notwithstanding subsections (a) and (d) and paragraphs (1), (2), and (3) of this subsection, the Secretary shall designate regional agencies or organizations which have entered into an agreement with him under this section to perform functions under such agreement with respect to home health agencies (as defined in section 1861 (o)) in the region.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in [subparagraphs (B) and (D)] *subparagraphs (B), (D), and (E)* of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services [for up to 100 visits during a calendar year];

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provided of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, [or]

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, [and] *or*

(III) a physician to a patient in a community mental health center; and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; [and]

(D) rural health clinic services [.]*; and*

(E) comprehensive outpatient rehabilitation services.

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of

each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), and (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, and

[(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraph (D) of section 1832(a)(2))—with respect to home health services, 100 percent, and with respect to other services (unless otherwise specified in section 1881), 80 percent of—

[(A) the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or

[(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

[(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services, and

[(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A).]

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D) and (E) of section 1832(a)(2))—

(A) with respect to home health services, the reasonable cost of such services, as determined under section 1861(v);

(B) with respect to other services (except those described in subparagraph (C) of this paragraph), the reasonable costs of such services, as so determined, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may such amount exceed 80 percent of such costs;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may such amount exceed 80 percent of such costs; and

(4) with respect to expenses in curred for physician services in a community mental health center, an amount determined in accordance with section 1814(b)(2).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology, *and (3) such deductible shall not apply with respect to home health services.* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or the equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantites of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who [is not an inpatient of a hospital] *is neither an inpatient of a hospital nor a patient of a community mental health center* at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is the smaller:

(1) $312.50, or

(2) 62½ percent of such expenses[.],

except that the provisions of this subsection shall not apply to expenses incurred by an individual as a patient of a community mental health center.

* * * * * * *

[LIMITATION ON HOME HEALTH SERVICES

[SEC. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

[(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.]

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, (ii) a

plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; [and]

(C) in the case of outpatient physicial therapy services, (i) such services are or were required because the individual needed physical therapy services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established *by a physician or by the speech pathologist providing such services* and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]*; and*

(E) in the case of comprehensive outpatient rehabilitation services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined). *With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than June 30, 1979, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractional relationship with, such home health agency from performing such certification and from establishing or reviewing such plan.*

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) No individual may enroll under this part more than twice.]

* * * * * * *

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th [consecutive] month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;

(2)(A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

* * * * * * *

(d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled; *except that in no case may the total amount of such increase exceed 30 percent of such monthly*

premium so determined. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

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Part C—Miscellaneous Provisions

definition of services, institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) * * *

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * * * *

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatry Education of the American Podiatry Association; [or]

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), unless (A) such inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients[.] *; or*

(8) a physician described in 1861(r)(6).

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and [subsections (i) and (n)] *subsection (i)* of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individual, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or

diagnostic services for purposes of such sections), section 1814(f)(2), and [subsections (i) and (n)] *subsection (i)* of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. *The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—*

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such man-

ner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, and (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i) waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

* * * * * * *

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (*of which at least two must be physicians described in subsection 1861 (r) (1) of this section*), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly

as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures esablished pursuant to title XIX be utilized instead of the procedures required by this section.

Agreements for Transfer Between Skilled Nursing Facilities and Hospitals

(1) A hospital and a skilled nursing facility *or community mental health center*, shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the skilled nursing facility *or community mental health center*, whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any skilled nursing facility *or community mental health center*, which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide *who has successfully completed a training program approved by the Secretary*;

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

[Post-Hospital Home Health Services

[(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from a skilled nursing facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or skilled nursing facility.]

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing;

(5) has in effect an overall plan and budget that meets the requirements of subsection (z); [and]

(6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization; *and*

(7) *meets such additional requirements as the Secretary finds necessary for the effective and efficient operation of the program;*

[except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and] except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

* * * * * * *

Physician

(r) The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), [(2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section

1814(a)(2)(E) of this Act,] *(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,* [(3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applied to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,] *(3) a doctor of podiatry or surgical chiropody for the purposes of subsection (s) of this section but only (unless clause (1) of this subsection also applies to him) with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814(a) and 1835 but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform,* [or] (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, [but only with respect to establishing the necessity for prosthetic lenses] *but only with respect to services related to the treatment of aphakia,* [or] (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray *or other chiropractic clinical findings* to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided, *or (6) a clinical psychologist who is licensed as such by the State (or in a State which does not license clinical psychologists as such, is legally authorized to perform the services of a clinical psychologist in the jurisdiction in which he performs such services) and who meets uniform minimum standards prescribed by the Secretary, but only for the purpose of section 1861(s)(1) and only with respect to the treatment of an individual who is an inpatient of a hospital (as defined in subsection (e) or (f) of this section) and is receiving inpatient hospital services for which payment may be made pursuant to section 1812 and only with respect to services which he is legally authorized to perform by the State or jurisdiction in which such services are furnished.* For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2) (A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies; *and*

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

* * * * * * *

Provider of Services

(u) The term "provider of services" means a hospital, skilled nursing facility, *comprehensive outpatient rehabilitation facility*, home health agency, *community mental health center*, or, for purposes of section 1814(g) and section 1835(e), a fund.

* * * * * * *

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, *community mental health center*, or home health agency (whether in its own right or as agent), with respect to services for which an in-

dividual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

* * * * * * *

Institutional Planning

(z) An overall plan and budget of a hospital, [extended care facility,] *skilled nursing facility*, *comprehensive outpatient rehabilitation facility*, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body; the administrative staff, and the medical staff (if any) of the institution or agency.

* * * * * * *

Community Mental Health Center Services

(bb) (1) The term "community mental health center services" means the following items and services furnished to an individual as an outpatient by a community mental health center or (to the extent permitted pursuant to subparagraph (A) of paragraph (2)) by others under arrangements with them made by the center—

(A) active diagnostic and therapeutic services furnished by qualified mental health professionals (as defined by the Secretary in regulations), including psychologists and psychiatric social workers;

(B) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered; and

(C) such items and supplies as are ordinarily furnished to outpatients by community mental health centers in connection with an active mental health program of diagnosis and treatment,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

(2) The term "community mental health center" means a facility which—

(A) meets the definition of a community mental health center under section 201 of the Community Mental Health Center Act and the regulations prescribed thereunder;

(B) is primarily engaged in providing outpatient mental health services;

(C) has a requirement that all mental health services are provided under the supervision of a physician;

(D) meets such requirements as the Secretary may prescribe with respect to staffing requirements and qualifications of the staff;

(E) maintains clinical records on all patients;

(F) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(G) has in effect an agreement with a hospital pursuant to subsection (l);

(H) in the case of a community mental health center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

(I) has appropriate procedures or arrangements (in compliance with applicable State and Federal law) for storing, administering, and dispensing drugs and biologicals; and

(J) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such center.

Comprehensive Outpatient Rehabilitation Services

(cc) (1) The term "comprehensive outpatient rehabilitation services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an outpatient of a hospital.

(2) The term "comprehensive outpatient rehabilitation facility" means a public or private institution which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy; and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) * * *

* * * * * * *

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, *or because of the severity of the dental procedure* requires hospitalization in connection with the provision of such services; or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns[, warts,] or calluses, the trimming of nails, and other routine hygienic care).

* * * * * * *

CONSULTATION WITH STATE AGENICIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

SEC. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (g)(4), (j)(11), [and (o)(6)] *(o)(6), and (cc)(2)(I)* of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), *or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2)* or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), *or whether a facility therein is a community mental health center as defined in section 1861(bb)(2)*. To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, or home health agency *or a community mental health center* (as those terms are defined in section 1861) may be treated as such by

the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center* clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center* clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, *community mental health center* clinic, agency, or organization.

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OVERPAYMENTS ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. (a) * * *

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[(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and—

[(1) no assignment of the right to payments was made by such individual before his death, and

[(2) payment for such services has not been made,

payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.]

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and no assignment of the right to payment for such services was made by such individual before his death, and payment for such services has not been made—

(1) if the person or persons who provided the services agree that the reasonable charge is the full charge for the services, payment for such services shall be made to such person or persons, and

(2) if the person or persons who provided the service do not agree that the reasonable charge is the full charge for the services, payment for such services shall be made on the basis of an itemized bill to the person who has agreed to assume the legal obligation to make payment for such services and files a request for payment (with such accompanying evidence of such legal obligation as may be required in regulations),

but only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.

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LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) * * *

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(e) Where payment for inpatient hospital services or extended care services may not be made under part A of this title on behalf of an individual entitled to benefits under such part solely because of an unintentional, inadvertent, or erroneous action with respect to the transfer of such individual from a hospital or skilled nursing facility that meets the requirements of sections 1861 (e) or (j) by such a provider of services acting in good faith in accordance with the advice of a utilization review committee, professional standards review organization, or fiscal intermediary, or on the basis of a clearly erroneous administrative decision by a provider of services, the Secretary may take such action with respect to the payment of such benefits as he determines may be necessary to correct the effects of such unintentional, inadvertent, or erroneous action.

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INTERNATIONAL AGREEMENTS

SEC. 1882. (a) The President is authorized to enter into agreements establishing reciprocal arrangements between the programs established by this title and the program of any foreign country under which similar services are provided directly to entitled individuals or under which insurance is provided to meet all or part of the expenses of entitled individuals for such services.

(b) Any agreement establishing such a reciprocal arrangement pursuant to this section shall specify—

(1) the nature and extent of payment to be made to or on behalf of (A) individuals entitled to benefits under this title for services covered under such title when such individuals are present in the foreign country and receive such services from persons who are authorized under the program of that foreign country to furnish them, and (B) individuals entitled to benefits under the program of that foreign country who receive such services in the United States from persons meeting such requirements or conditions as are required under such title;

(2) such limitations on the nature and duration of services for which payment may be made in one country to individuals entitled to benefits under the program of the other country, as the

President deems appropriate, except that no agreement shall authorize any individual to receive benefits in the United States on a reciprocal basis in excess of those provided for individuals entitled to benefits under this title;

(3) such limitations on entitlement of individuals to benefits on a reciprocal basis under an agreement in the United States and in the foreign country, as the President deems appropriate, except that no agreement shall provide entitlement to benefits under this title in the United States for an individual who does not meet the requirements for entitlement applicable under such title with respect to age or medical condition;

(4) the methods by which the cost of providing services to persons on a reciprocal basis shall be shared equitably by the persons receiving such services and by the respective programs of the United States and the foreign country; and

(5) such other provisions, not inconsistent with this section, as the President deems appropriate.

(c) The Secretary shall make rules and regulations and establish procedures which are reasonable and necessary to implement and administer any agreement which has been entered into in accordance with this section.

(d) Pending the conclusion of an agreement under this section with a foreign country, the Secretary is authorized to enter into interim arrangements with any hospital in that country which is accredited by the Joint Commission on Accreditation of Hospitals, or such other hospitals as the Secretary finds meet health and safety standards equivalent to those required under this title for hospitals in the United States and which are accredited in the foreign country concerned, under which payment may be made for inpatient hospital services, as defined in section 1861, to or on behalf of an individual who is entitled to such benefits under part A of this title. For purposes of making payment under such an interim arrangement, the Secretary shall use whichever of the methods provided for in section 1814(f) he finds appropriate, except that any payments made under part A of this title to the individual or to the hospital shall be reduced to the extent that the individual has no legal obligation to pay for any items or services furnished to such individual by reason of the laws of the foreign country in which the hospital is located, or such individual's membership in an insurance plan that provides for payment for such items or services.

SECTION 7 OF THE RAILROAD RETIREMENT ACT OF 1974

POWERS AND DUTIES OF THE BOARD

SEC. 7. (a) * * *

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(d) (1) The Board shall, for purposes of this subsection, have the same authority to determine the rights of individuals described in subdivision (2) to have payments made on their behalf for hospital

insurance benefits consisting of inpatient hospital services, *community mental health center services*, posthospital extended care services, [posthospital] home health services, and out patient hospital diagnostic services (all hereinafter referred to as "services") under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals to whom such sections and such parts apply. For purposes of section 8, a determination with respect to the rights of an individual under this subsection shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

(2) Except as otherwise provided in this subsection, every person who—

(i) has attained age 65 and (A) is entitled to an annuity under this Act or (B) would be entitled to such an annuity had he ceased compensated service and, in the case of a spouse, had such spouse's husband or wife ceased compensated service; or

(ii) has not attained age 65 and (A) has been entitled to an annuity under section 2 of this Act, or under the Railroad Retirement Act of 1937 and section 2 of this Act, or could have been includible in the computation of an annuity under section 3(f)(3) of this Act, for not less than 24 [consecutive] months and (B) could have been entitled for 24 [consecutive] calendar months, and could currently be entitled, to monthly insurance benefits under section 223 of the Social Security Act or under section 202 of that Act on the basis of disability if service as an employee after December 31, 1936, had been included in the term "employment" as defined in that Act and if an application for disability benefits had been filed,

shall be certified to the Secretary of Health, Education, and Welfare as a qualified railroad retirement beneficiary under section 226 of the Social Security Act.

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